AIDS Brief

For sectoral planners and managers

Military Populations

HIV/AIDS affects and will continue to affect economies and society at all levels from the individual to the macro-economy. The most immediate effects are, of course, experienced by the person who becomes sick and then by his or her family or household. Between the extremes of individual and macro-economy there are also effects on communities, enterprises and economic and social sectors. It is at these middle levels, which include both productive and service sectors, that interventions may be most urgently required. This AIDS Brief provides some ideas as to how military populations may be affected and what types of response may be required.

Background

Throughout the world, military personnel are among the most susceptible populations to HIV and AIDS. They are mostly young and sexually active, are often away from home and governed more by peer pressure than social convention, are inclined to feel invincible and take risks, and are surrounded by opportunities for casual sex. Deployment to unsettled areas increases their chances of acquiring HIV, as they are exposed not only to socially disrupted settings where sexually transmitted infections (STIs) may abound, but also to the possibility of infection through wounding and contaminated blood. A frequent absence of adequate HIV testing and monitoring equipment, especially under field conditions, exacerbates the problem of avoiding exposure to the disease.

HIV transmission is five to twenty times more likely where other STIs are present; peacetime STI infection rates among military populations are two to five times higher than in civilian societies. Indeed, evidence suggests that some soldiers consider the acquisition of an STI to be a symbol of sexual prowess and proof of manhood. During wartime, military risk increases by as much as 100 times that of civilians.

As a result of such factors, the HIV/AIDS pandemic now represents a direct threat not only to socio-economic integration and political stability, but also to national and international security and peace in many parts of the world. In this light, the development of effective military HIV/AIDS prevention and care programmes assumes vital and immediate importance.

Definition

For the purposes of this AIDS Brief, military populations comprise members of national armed forces, including regular army, navy and air force contingents, militia and reserve units, and paramilitary/guerrilla groups.

Although all militaries are affected by HIV/AIDS, those of the developing world are especially vulnerable. In sub-Saharan Africa, for example, ministries of defence report averages of 20% to 40% HIV-positivity within their armed services, with rates of 50% to 60% in a few countries where the virus has been present for over 10 years. Such attrition causes loss of continuity at command level and within the ranks, increases costs for the recruitment and training of replacements, and reduces military preparedness, internal stability and external security. In this sense, HIV/AIDS can easily become a regional destabiliser and a potential war-starter.

Unlike quickly-developing diseases such as malaria and dysentery, HIV/AIDS is not a war-stopper (it does not immediately take soldiers out of the front line). Thus many militaries have been slow to initiate HIV/AIDS programmes and have remained distanced from civilian programmes. As the impact of the disease becomes more apparent, however, most senior medical and, to a lesser extent, line officers, recognise the urgent need to provide information on avoiding infection. This includes promoting condom use, maintaining strict blood-safety procedures, and prevention and treatment of other STIs. Leaders also increasingly acknowledge that HIV/AIDS cannot be combated in isolation, but requires close co-operation with civilians in the public and private sectors, and cross-national civil-military collaboration.

Key Elements

HIV testing

For armed services in all world regions, no other health-related issue is as controversial as the question of universal testing for HIV. Those opposed to mandatory testing argue that it is inconclusive, expensive, and in direct violation of human rights to privacy and freedom from discrimination. Advocates maintain that the resulting statistical information is important in maintaining military readiness, in extending the length and quality of life of personnel and those with whom they come into contact, in evaluating the disease and in establishing preventive intervention.

On medical and cost-benefit terms, and also for human rights reasons, the World Health Organisation is opposed to routine HIV testing without consent. Only a few militaries have adopted mass testing policies. Of these, the U.S. armed forces require compulsory HIV screening of all recruits, biannual phased serological testing of active-duty and reserve units, screening of blood donors, and periodic testing of groups exposed to high risks including STI patients and some recipients of blood and blood products.

In many countries, however, military leaders are reconsidering the merits of universal testing. This has been prompted by the mounting costs, organisational dislocation and threats to mission fulfilment caused by the HIV virus. One possibility involves the release of test results, with policy options ranging from complete confidentiality to informing commanding officers and the families and / or sexual partners of test subjects. In Third World militaries especially, decisions on mandatory testing are influenced by questions of foreign training, peacekeeping participation, staffing, demobilisation, provision for the HIV-infected, and general stability.

Foreign military training

Because of personnel losses created by HIV / AIDS, overseas military training has assumed ever-greater importance for many Third World governments. Some countries offering training require that those selected be certified as HIV-seronegative. This prompts commanders either to require screening of candidates or to select host-countries which require no such tests. In a few cases, testing has been circumvented by HIV-positive nominees submitting false test results obtained from HIV-negative surrogates.

Peacekeeping

HIV prevention has gained a new urgency with the increasing deployment of soldiers on United Nations and other peacekeeping missions. By their very nature, these operations enhance exposure to disease. This risk is compounded when peacekeeping contingents are expected not only to stand between contending forces, but also to separate them, help effect demobilisation and create institutions to maintain the peace.

Short-term assignments can thus subtly be transformed into lengthy peacemaking efforts, often in situations where HIV-seroprevalence is already high. The presence of refugees and displaced persons further heightens risk of exposure to HIV and other STIs; by late 1994 there were about 22 million of these uprooted civilians in Africa alone. In earlier times, military STI patients were usually cured before returning home. HIV, however, requires military and civilian populations to deal with a chronic and incurable disease with a high rate of transmission from the field to home and vice versa.

Countries contributing peacekeeping units are therefore concerned that returning troops might transfer HIV to their families. Host-country leaders express equal worry that foreign peacekeepers may transmit HIV to their own people. The UN Department of Peace-Keeping Operations recommends that training in HIV prevention be required of all militaries supplying peacekeepers, voluntary or mandatory HIV screening be employed prior to deployment, and troops and personnel infected with HIV and / or other STIs should not be deployed.

This is not always done. For example, several national contingents deployed to Somalia in the early 1990s were not tested before departure; none of the other governments participating in the Somali peacekeeping mission questioned this lapse for fear that those concerned would cancel their involvement. Conversely, peacekeeping participation has become significant to a number of Third World governments, which use the proceeds to help fund their defence ministries.

Military staffing

Universal screening and testing for HIV may have adverse effects on military staffing. Stigmatisation of those rejected before or after enlistment may seriously deplete potential military personnel.

If, however, the debilitating symptoms of HIV infection can be postponed in certain controllable situations, there may be no valid reason to deprive the HIV-positive of active service, promotion and rank, especially among highly trained personnel. Highly regulated military environments would seem especially conducive to such regimes. More conclusive evidence is needed about human environmental factors which may slow the development of symptoms resulting from HIV infection.

Demobilisation

International donor and lending institutions often require demobilisation of militaries and reduced defence spending as a condition of co-operation. Such reductions in force may result in smaller and more economical military structures, but may also lead to the further spread of HIV by discharged personnel.

AIDS care

As AIDS has become the leading cause of death in many military organisations, several controversial questions arise concerning the interface of military and civilian populations. For example, should special AIDS clinics be established for soldiers and their families? At what point should HIV/AIDS patients be discharged and sent home, and with what consequences for spread of the disease? Should full medical benefits be provided for discharged AIDS patients and their dependants? What kinds of financial, legal, and other benefits should be extended to the survivors of deceased? In short, should the armed forces and their dependants receive privileged treatment as a "protected class" within societies exposed to HIV/AIDS?

Stability

Growth in AIDS-related deaths among young Third-World adults is likely to exert a highly negative impact on economic, political, and military stability. In military administrations especially, stability may be seriously undermined by depletion in the ranks of key officials and their potential successors.

Sectoral Coping Strategies

Military medical services generally agree that workable approaches to HIV prevention and AIDS care should embody eight main components:

1. information, education, and communication (IEC) programmes targeted toward HIV and other STI prevention;
2. condom procurement, dissemination, and promotion;
3. IEC initiatives to advance STI care-seeking behaviour;
4. prevention of HIV transmission through blood transfusions;
5. prevention of prenatal transmission;
6. care and support for those afflicted with AIDS, both before and after discharge from service;
7. close integration of military prevention and care activities within civilian AIDS programmes;
8. testing for the HIV virus combined with pre- and post-test counselling.

The only controversial aspect of these strategies concerns whether HIV testing should be voluntary or mandatory for in-service personnel and / or recruits.

Where put into effect, civilian national AIDS programmes largely determine the parameters of military HIV/AIDS policies. To a greater or lesser extent, military strategies are also co-ordinated with civilian government agencies and non- governmental organisations (NGOs).

Among Third World countries, Botswana provides one of the most comprehensive examples of a military sectoral response. Under specific civilian and military policies, HIV-positive members of the Botswana Defence Force (BDF) are treated the same as uninfected personnel. They are fully deployable within Botswana until a medical officer advises otherwise, and may not be discharged until they fall below minimum performance standards. Soldiers who no longer meet these criteria are discharged for medical reasons, with full medical benefits for themselves and their beneficiaries. HIV-positive personnel who choose not to remain on active duty may apply for discharge on compassionate grounds, and also receive full medical benefits.

HIV-positive military trainees, including ordinary recruits and officer cadets, complete their training and are assigned to duty. If clinical deterioration means that they fall below retention standards, they are discharged on medical grounds.

Irrespective of HIV status, all members of the BDF and their families receive education and counselling on HIV prevention. Thus the BDF currently maintains one of the world's most constructive approaches to HIV in the military, although as the epidemic gains momentum these policies may require reappraisal.

Except under explicitly stipulated conditions, HIV examinations are voluntary, whether for recruits, soldiers suspected of being HIV-positive, STI patients, rape victims, or military medical beneficiaries / non-beneficiaries who may have had sexual conduct with or received blood from active-duty personnel.

BDF members selected for training in countries requiring HIV screening can choose to be tested or to decline the training, with no penalties in terms of career advancement. The test results of those who are examined are held in strict confidence and only released to

relatives and / or partners with their consent.

This voluntary testing policy carries one partial exception - pilots and troops destined for peacekeeping missions. If a fighter-pilot becomes HIV symptomatic, he is tested; if found to be HIV-positive his pilot's commission is cancelled. HIV-positive transport pilots may continue to fly until they fall below an established standard of fitness, after which they retire with full benefits. HIV-positive soldiers and aircrews are not eligible for deployment outside Botswana.

Strategies to Reduce Vulnerability to HIV/AIDS

For both the military sector and the civilian society of which it is part, strategies to reduce vulnerability to HIV/AIDS must embody five essential components - they must:

1. foster a positive social environment conducive to value change so that changes in terms of sexual behaviour can result;
2. seriously attempt to bring infection rates to a level of stasis and offer support to the already-infected and their dependants;
3. minimise the short-term psychological, social, economic, and political effects of the HIV/AIDS pandemic on individuals, communities and civilian / military institutions;
4. counter long-term reductions in standards of living, productive capacities, and civil order; and
5. contain innovative and yet realistic organisational and funding provision to maximise their impact on military and civil populations.

The chief military-related target groups are active-duty and reserve forces and their dependants; sex workers catering to the armed forces; voluntary and / or conscripted recruitment pools.

On the basis of epidemiological, socio-cultural, and behavioural research, the most straightforward aspect of reducing vulnerability to HIV entails efficient distribution and adequate supply of condoms, blood-testing equipment and disposable medical supplies. On-site (media-independent) and remote (media-dependent) preventive information, education, and communication programmes, together with efforts to identify and treat other STIs, are also required. The more difficult aspects are ensuring adequate funding and inter-agency co-ordination within and among militaries, and establishing effective linkages between military and civilian institutions. However, the armed services may themselves offer distinct advantages in attacking these problems. With their regularised channels of internal and international communication, and their relatively sophisticated health-care and command systems, militaries may be ideally positioned to interact with each other and jointly to devise risk-reduction initiatives that can serve as models for their societies at large. In addition, employing soldiers in community peer-education roles may afford a partial alternative to economically well-motivated but politically destabilising reductions in force, and may also improve the status of the military in civilian society.

In policy terms, reducing vulnerability to HIV/AIDS in military and counterpart civilian populations will necessitate the following changes:

- greater training co-operation and epidemiological data sharing between the civilian and military sectors;
- encouraging greater international co-operation in HIV prevention and AIDS alleviation through increased South-South, South-North, and North-South information and resource transfers;
- changing the perception of HIV/AIDS from that of an immediate medical crisis and domestic political issue to that of a serious but approachable long-term obstacle to national and international stability, peace, and development;
- inter-sectoral collaboration that moves beyond traditional ministerial divisions and time-honoured distinctions between the roles of private and public, or civil and military, to promote the common welfare.

☑ Checklist

❑ ***Vulnerability***

Spread of HIV virus:

- ❍ Initially hidden but increasing infection
- ❍ Military personnel among core groups for HIV acquisition and transmission

AIDS-related illness and death:

- ❍ Spread of HIV continues with more civilian and military illness and death

Survivors:

- ❍ Surviving military dependants left without support

☑ Checklist (continued)

Immediate security impact:
- ❍ Depletion of force strength
- ❍ Loss of command capacity

Long-term potential impact:
- ❍ Social and political unrest
- ❍ Loss of control over national security
- ❍ Generalised breakdown of public order

❑ ***Responses***

Spread of HIV virus:
- ❍ Behaviour change through information, education and communication programmes encouraging condom use
- ❍ Ensuring adequate numbers, quality, and appropriately distributed condoms
- ❍ Prevention through condom use, blood screening
- ❍ Prevention impact assessment by periodic voluntary or mandatory testing for HIV or other STIs.
- ❍ Human rights protection: confidentiality of HIV test results and protection of job security until medical discharge from service becomes necessary

AIDS-related illness and death:
- ❍ Social and psychological support through pre-test and post-test counselling of military personnel and of their dependants
- ❍ Employment and income maintenance: protection of employment security and possibility of advancement in rank until medical discharge is necessary
- ❍ Confidentiality, care and treatment
- ❍ Legal protection
- ❍ Provision of continuing medical care of HIV-infected personnel, discharges and their dependants

Survivors:
- ❍ Emergency assistance to dependants of deceased personnel through temporary continuation of military salary and provision of death benefits including expenditures to cover funeral costs
- ❍ Reintegration of survivors within their communities through assistance in relocation of survivors' households and through provision of educational benefits for surviving children
- ❍ Assistance in protection of family property rights

Immediate security impact:
- ❍ HIV impact monitoring and increases in numbers of personnel to maintain armed forces' strength and command and control capacity
- ❍ Protection and strengthening of military recruitment pool through HIV prevention-related information, education and communication campaigns targeted towards adolescents and through recruitment limited to literate school-leavers
- ❍ Strengthen health and social welfare sectors through increased domestic and donor-assisted civil-military co-operation in the HIV / AIDS areas

Long-term potential impact:
- ❍ National and international actions to reduce adverse effects on people and their communities through greater HIV / AIDS information and resource-sharing among militaries
- ❍ Change perception at senior military and civilian levels from viewing HIV only as an immediate medical crisis to HIV treated as a serious but approachable challenge to national and international security, peace and socio-economic development
- ❍ Increased inter-sectoral co-operation in HIV prevention and AIDS care, moving beyond traditional ministerial distinctions between the roles of military and civilian institutions and between public and private sectors, to promote common welfare - e.g. encouraging greater military co-operation with effective NGOs working in HIV prevention

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Key Contact

Civil-Military Alliance to Combat HIV and AIDS, P O Box 333, Norwich, Vermont, 05055, U.S.A. Telephone (802) 649-5296. Fax: (802) 649-2331.

Prepared by Rodger Yeager, Director of International Studies and Professor of Political Science, West Virginia University, Morgantown, WV 26506, USA.

Series Editors: Professor A. Barnett, Mr E. Blas and Professor A. Whiteside